Comments of Access Living on the Report of the Governor's Health Reform Implementation Council, February 7, 2011

Established in 1980, Access Living is a non-profit, Chicago-based disability rights and service organization that provides individualized, peer-based services for people with disabilities. With a strong influence in public policy and social reform, Access Living is a leading force in the community. Committed to challenging stereotypes, protecting civil rights and breaking institutional and community barriers, Access Living is a nationally recognized change agent at the forefront of the disability rights movement.

Community First Choice Option

Section 2401 of the federal Affordable Care Act amends the Social Security Act to enact the "Community First Choice Option." This option permits states to provide home- and community-based attendant services and supports for Medicaid-eligible persons who choose to participate in the plan, in exchange for a 6% *increase* in the federal medical assistance percentage (FMAP) funding for such services.

Access Living strongly urges this Council to recommend implementation of the Community First Choice Option as an essential component of community reintegration that is not only desirable for people with disabilities but is mandated under the consent decrees issued and being negotiated in federal court cases affecting people with disabilities (*Williams v. Quinn*, 05 C 4673 (N.D. Ill.); *Ligas v. Maram*, 05 C 4331 (N.D. Ill.); *Colbert v. Quinn*, 07 C 4737 (N.D. Ill.)). In addition, exercise of this option may actually *save* the State Medicaid dollars, particularly when it merely transfers already eligible individuals from expensive institutional care to community settings.

Representatives of Access Living were gratified to discover at this Council's hearing on February 7, 2011, that omission of a recommendation of the CFC Option in the Council's report did not imply its exclusion from the Council's consideration. In light of the critical importance of implementing this option in Illinois, Access Living welcomes, and seeks, an opportunity to meet with representatives of the Council and other stakeholder groups with respect to ways in which the Option can be implemented in Illinois. Access Living also recommends that this Council reach out to the staffs of HHS and CMS at the federal level, who are currently formulating rules regarding the CFC Option. See http://www.ahcancal.org/advocacy/Pages/UpcomingProposedandFinalRulesPursuanttothe.aspx

The Exchange as a Quasi-Governmental Entity: Need for Conflict of Interest Provisions

While Access Living applauds this Council for eliminating the option of an Exchange that is placed within an existing State agency and for creating distance from the State that allows for greater independence from political influence, we emphasize that strong conflict of interest provisions must be built into even a quasi-governmental entity. Only through such provisions can an actual impropriety or appearance of impropriety be avoided, certainly an essential feature of an Exchange that is designed to serve a huge number of individuals in Illinois.

A notable example is California's Exchange, an independent public entity within state government with a board appointed by the Governor and the legislature. Despite the board's independence, members of both the board and the board's staff are subject to strict conflict-of-interest provisions. Title 22 of California's Government Code, the California Health Benefit Exchange Act, provides in Section 100500(f)(1):

> A member of the board or of the staff of the Exchange shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a carrier or other insurer, an agent or broker, a health care provider, or a health care facility or health clinic while serving on the board or on the staff of the Exchange. A member of the board or of the staff of the Exchange shall not be a member, a board member, or an employee of a trade association of carriers, health facilities, health clinics, or health care providers while serving on the board or on the staff of the Exchange. A member of the board or of the staff of the Exchange shall not be a health care provider unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

Inclusion in Illinois of an identical or similar conflict of interest policy will prevent the professional and personal interests of Exchange board members and their staff from influencing, or appearing to influence, the performance of their duties on behalf of the Exchange and the people of Illinois. Access Living urges this Council to include this recommendation in its report on governance of the Illinois Exchange.

Increase the Minimum Medical Loss Ratio

An 85% medical loss ratio is only the *minimum* required by the Affordable Care Act. Access Living proposes that Illinois raise that loss ratio to 90% in the large group market and to 85% in the individual and small group markets.

According to a December 2009 report issued by the Main Street Alliance, a national policy-oriented network of small business coalitions, leading health insurance companies used 95 cents on every premium dollar in 1993 to pay for medical care. Even with a 95% medical loss ratio, those companies managed to make tidy profits that easily covered executive salaries, executive bonuses, sales commissions, marketing and advertising, and administrative expenses. The public Medicare program has consistently had a medical loss ratio greater than 97% since 1993.

Health care insurers will benefit from the individual mandate contained in the Affordable Care Act and by access to consumers on the Exchange. In turn, by increasing the allowable minimum medical loss ratio by 5% above the minimum mandated by the Affordable Care Act, Illinois can redirect some of the profits of those insurers into quality health care services so badly needed by people with disabilities and into savings for employers, families, and individuals who purchase insurance on the Exchange.
http://mainstreetalliance.org/wordpress/wp-content/uploads/Ensuring-Value-for-Premiums.pdf

Workforce Training

Access Living commends this Council on its recommendation that a Health Care Workforce work group be convened to address not only workforce shortages but education and training for health care professionals. We note that this Council recommends required areas to be covered by a new training plan and that such areas include, generally, the capture of funding under the Affordable Care Act. In that regard, Access Living wishes to draw attention to the numerous training grants relevant to people with disabilities and to reduction of health disparities among this population. Available grants include:

- Priority grants to medical schools that provide training in the care of vulnerable populations including persons with disabilities. ACA, Section 5301.
- Grants for training opportunities for direct care workers employed in long-term care settings who agree to work for a minimum of two years in the field of geriatrics, disability services, long term services and supports, or chronic care management. ACA, Section 5302.
- Grants to institutions teaching dentistry with programs targeting vulnerable populations. ACA, Section 5303.
- Grants for training and curriculum development in cultural competency, reduction of health disparities, and aptitude for working with individuals with disabilities. ACA, Section 5307.
- Grants for training in core competencies for personal or home care aides, including needs of people with disabilities. ACA, Section 5507.

Workforce adequacy and training issues are among the most troubling and intractable in the area of health care services for people with disabilities, including chronic conditions.[1] An energetic effort to seek funding for the special grant opportunities in the Affordable Care Act will be a much-needed response, and Access Living urges this Council to seek out these training opportunities. Additionally, Access Living urges this Council to consider the high unemployment rate of persons with disabilities and whether the hiring of people with disabilities in health care can be incentivized by the State.

[1] M. Elizabeth Sandel, M.D., commentator in "Who Will Provide Care for People with Complex Physical Disabilities?," *Physical Medicine & Rehabilitation*, Volume 2, Issue 10, Pages 950-956, October 2010.